Appendix 28
Estate Recovery Program Notification of Death Form

Department of Health and Social Services
Division of Health
DOH 1113A (4/93)

State of Wisconsin

ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH

NAME OF DECEASED RESIDENT: _____

SOCIAL SECURITY NO: _____

DATE OF DEATH: _____

AMOUNT IN PERSONAL ACCOUNT: _____

DOES THE DECEASED HAVE A:
(Please circle appropriate response*)

SURVIVING SPOUSE	NO	UNKNOWN
SURVIVING MINOR CHILDREN	NO	UNKNOWN
SURVIVING DISABLED CHILDREN	NO	UNKNOWN

COMPLETED BY: _____
(Name)

_____
(Position)

NURSING HOME:

_____
(Name)

_____
(Address)

_____

Mail to:

Wisconsin Department of Health and Social Services
Bureau of Health Care Financing
Coordination of Benefits Unit
P.O. Box 309
Madison, WI 53701-0309

* Please do not complete this form if a yes response is appropriate to any of the three questions.